

TRICARE Plus: A Cost, Capacity and Enrollment Analysis

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14. ABSTRACT This study looks at the TRICARE Plus (TP) impact on the cost of primary care (PC) within the Naval Hospital Pensacola (NHP) catchment area by determining current costs and NHPs TRICARE Prime enrollment capacity. Recommended TRICARE Plus options are provided based on NHPs and the Military Health System (MHS) costs and capacity. NHPs fiscal year 2001 (FY01) PC capacity was nearly 50 percent, which equated to over 45,000 unfilled visits. NHPs and the MHS PC costs in FY01 for the Pensacola catchment area were \$17,357,609 and \$23,753,608 respectively. Increasing enrollment will reduce these costs. Over 28,000 eligible beneficiaries in the Pensacola catchment area are not enrolled in TRICARE Prime at NHP. Recapturing a portion of these beneficiaries could result in \$2.25 million savings for the MHS and decrease the cost of a NHP PC visit to \$44. Specific enrollment strategies will determine actual savings. It is recommended that NHP recapture all Active Duty Dependents (ADD) currently enrolled in the Civilian Provider Network (CPN) while actively enrolling TRICARE Plus eligibles. By FY06, ADD Civilian Prime Network recaptures should increase NHPs TRICARE Prime enrollment nearly 4500. Additionally, TRICARE Plus enrollment could increase by over 3000. Estimated annual cost savings for NHP and the MHS would be \$90 thousand and \$2.25 million respectively.					
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Abstract

This study looks at the TRICARE Plus (TP) impact on the cost of primary care (PC) within the Naval Hospital Pensacola (NHP) catchment area by determining current costs and NHP's TRICARE Prime enrollment capacity. Recommended TRICARE Plus options are provided based on NHP's and the Military Health System (MHS) costs and capacity.

NHP's fiscal year 2001 (FY01) PC capacity was nearly 50 percent, which equated to over 45,000 unfilled visits. NHP's and the MHS PC costs in FY01 for the Pensacola catchment area were \$17,357,609 and \$23,753,608 respectively. Increasing enrollment will reduce these costs.

Over 28,000 eligible beneficiaries in the Pensacola catchment area are not enrolled in TRICARE Prime at NHP. Recapturing a portion of these beneficiaries could result in \$2.25 million savings for the MHS and decrease the cost of a NHP PC visit to \$44. Specific enrollment strategies will determine actual savings.

It is recommended that NHP recapture all Active Duty Dependents (ADD) currently enrolled in the Civilian Provider Network (CPN) while actively enrolling TRICARE Plus eligibles. By FY06, ADD Civilian Prime Network recaptures should increase NHP's TRICARE Prime enrollment nearly 4500. Additionally, TRICARE Plus enrollment could increase by over 3000. Estimated annual cost savings for NHP and the MHS would be \$90 thousand and \$2.25 million respectively.

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TRICARE PLUS: A Cost, Capacity and Enrollment Analysis

Introduction

Conditions which prompted the study

TRICARE is the U.S. military's health benefit plan that provides three options of care to its eligible beneficiaries. The first option, TRICARE Prime, is the military's equivalent to a hybrid staff model Health Maintenance Organization (HMO). Qualified beneficiaries must enroll in TRICARE Prime and are assigned a Primary Care Manager (PCM) at their local Military Treatment Facility (MTF) or with a local civilian network provider. TRICARE Prime provides the least out-of-pocket expense for the beneficiary. The other two options, TRICARE Extra and TRICARE Standard (traditional CHAMPUS) are similar, except TRICARE Extra is much like a Preferred Provider Organization (PPO), whereby the outpatient cost share for the beneficiary is reduced when services are rendered by a network provider. Beneficiaries using either of these options have more flexibility in receiving care but bear a higher cost in the form of annual deductibles and cost sharing. Currently, the annual deductible is \$150 per beneficiary/\$300 per family (\$50/\$100 for junior enlisted E-5 and below). The outpatient cost share is 20 and 25 percent after the annual deductible has been met for active duty dependents and retirees under the age of 65 respectively. Services provided by a TRICARE Extra provider receive a 5 percent discount off these cost shares. Out-of-pocket expenses are limited to \$1000 per family for active duty and \$3000 for a retiree family. Thereafter, TRICARE pays 100 percent of appropriate medical care (TRICARE, 2001).

Before October 2001, TRICARE provided healthcare coverage for active duty (AD) personnel and their dependents (ADD), retired personnel under the age of 65 and their dependents (NADD), and other qualifying individuals. Once a retired beneficiary reached the

age of 65, they were no longer eligible for TRICARE benefits with limited exceptions. They could be seen space available in MTFs and their medications could be filled at MTF pharmacies if the medication was part of the MTFs formulary. However, much “space available” care at MTFs vanished during the 1990s due to downsizing. Many military retirees over the age of 65 and their eligible dependents (NADD>65) were enraged at losing their healthcare benefit at a MTF. They felt that “free healthcare” was a right based on documented promises made by the government when they entered military service. One of their arguments was that Medicare differed from military health care in that it did not have a pharmacy benefit (Harris, 2000).

Through strong legislative lobbying by retiree organizations, TRICARE Senior Prime, a Medicare subvention demonstration project, was piloted at six select locations during the late 1990s. It ended December 31, 2001. These demonstration projects allowed a specified number of NADD>65 beneficiaries to enroll in the military’s HMO program and receive the same care and access standards afforded TRICARE Prime patients. Each demonstration project was geographically dispersed and only affected a small portion of the NADD>65 population. These demonstration projects did not address the healthcare needs for the majority of military retirees over the age of 65. Additional lobbying to Congress by military affiliated organizations was performed on behalf of these beneficiaries. These efforts paid off in 2000 with the passing of the National Defense Appropriations Act of 2001 (NDAA). The NDAA made sweeping changes in military healthcare reform.

The NDAA introduced a few, yet significant, healthcare benefits for the NADD>65 population starting in fiscal year 2002 (FY02). Title VII Subtitle B of the DAA (Senior Health Care) updated the pharmacy benefits to include access to retail pharmacies and the National Mail Order Pharmacy (NMOP). This benefit began April 1, 2001. Sections 712 and 713 under the

aforementioned Subtitle established a new benefit that has been tabbed “TRICARE for Life” (TFL). This benefit started in October 2001 and essentially made TRICARE a secondary payer to MEDICARE for approved services. NADD>65 beneficiaries must be enrolled in both MEDICARE A and B in order to be eligible for TFL. However, a portion of the NADD>65 population do not have Medicare Part B and/or would still prefer to receive their care at the local MTF. Prior to October 2001, no TRICARE MTF care option existed for this population other than space available care. However, a small portion of the NADD>65 population has been empanelled in certain Family Practice teaching hospitals for Graduate Medical Education (GME) residency programs. This population currently accounts for approximately 2000 empanels at Naval Hospital Pensacola (NHP). Since no TRICARE option existed for the care of the NADD>65 population at a MTF, a new option, TRICARE Plus (TP), was developed to fill this void.

TRICARE Plus allows any beneficiary, including NADD>65, not currently enrolled in TRICARE Prime or other Health Maintenance Organizations (HMOs) to enroll in TRICARE Plus (Assistant Secretary of Defense, 2001). It potentially affects over 12,000 NADD>65 beneficiaries that reside in the Pensacola catchment area. TRICARE Plus works much like TRICARE Prime in that enrollees are assigned a PCM with the local MTF and have similar access standards for primary care. However, there are no guaranteed access standards for specialty care. Specialty care is provided on a space available basis. The main advantages to TRICARE Plus are that enrollees do not have an enrollment fee and NADD>65 beneficiaries are not required to have Medicare Part B coverage to qualify. However, any NADD>65 beneficiary with only Medicare Part A would subject themselves to 100 percent of the cost of any civilian care because TRICARE only becomes secondary payer when the NADD>65 beneficiary has

Medicare Part B coverage. There are some disadvantages to TRICARE Plus. First, TRICARE Plus enrollees must reside in the MTFs catchment area (50 miles) as the program is only utilized by MTFs. Additionally, TRICARE Plus is MTF specific and not portable. Guaranteed access standards are only specific to the enrolled facility. If a TRICARE Plus enrollee leaves an area that has a participating MTF, there is no guarantee that another MTF will be able to enroll them in TRICARE Plus or whether that MTF even participates in TRICARE Plus. Lastly, MTF commanders can elect not to participate in TRICARE Plus (TMA, 2001). Currently, no additional funding is afforded commanders that participate in TRICARE Plus. Therefore, TRICARE Plus will have a significant impact on any MTF that elects to participate, both in cost of care and capacity management (quality of care and access to care), in treating this new beneficiary category. Validating capacity and cost of providing TRICARE Plus at an MTF is crucial.

Statement of Problem

Capacity management and cost efficiency are concerns to any MTF commander, but a unique twist presents itself with regards to TRICARE Plus particularly the NADD>65 population. Since the NADD>65 population is traditionally seen more often and their care more costly than most current Military Treatment Facilities (MTFs) beneficiaries, the impact of treating this population is not fully understood. This particular study will determine the capacity at NHP and the most cost efficient measures to treat the NADD>65 population enrolled in TRICARE Plus that reside in the Pensacola catchment area.

Literature Review

Cost of Care. Cost of care is derived in a number of ways. Costs can be associated directly with the care received or spread across an organization through a step-down process.

There are three traditional methods used for cost accounting in medical services: historical method, margin, and weighted-average method. Historical method looks at what an organization has traditionally charged and what a payor has paid. Generally, margin looks at cost plus profit margin. Lastly, weighted-average accounting looks at the total costs divided by the number of procedures (i.e. visits) in order to arrive at an average cost per event (Zelman, McCue, and Millikan, 1998). In the DOD healthcare system, the Military Expense Performance Reporting System (MEPRS) is used for cost accounting purposes and most closely resembles a weighted-average costing system. In 1999, the DoD average MTF cost per outpatient visit was \$105 (TRICARE, 2001). Per visit cost for Civilian Prime Network, TRICARE Extra, and TRICARE Standard was \$116, \$99, and \$117 respectively in FY 2000 for services provided in the NHP catchment area (Lead Agent Region 4, 2001). The current cost impact of TRICARE Plus is unknown.

TRICARE Plus is a new aspect of the overall TRICARE Health Plan. Very little research is available on its impact on MTFs. However, TRICARE Plus closely matches a three-year demonstration project, MACDILL 65, which ended in September 2001. It provided medical care for 2000 NADD>65 beneficiaries at the MacDill AFB MTF. While MTF size and capabilities may cause variations among facilities, the MACDILL 65 project noted that per member per month (PMPM) cost for treating the NADD>65 population was \$80.90, over half which was attributable to pharmaceuticals (BUMED, 2001). Center for Medicare (CMS) data for calendar year 2000 (CY00) indicated \$6937 was the average amount spent on healthcare for each Medicare enrollee (CMS, 2001). This figure increases to nearly \$700 PMPM for Medicare enrollees in the state of Florida. The average amount of an outpatient visit for a Medicare recipient is \$157 (HHS, 2001). The low PMPM cost of the MACDILL 65 project compared to

the PMPM rate for Florida Medicare enrollees suggest cost efficiencies could be met through NADD>65 care being received at a MTF.

NHP spent in excess of \$11 million providing over age 65 care in FY01. The majority of this care was spent on the Medicare population empanelled in the GME residency program. However, some of this care was spent on the non-eligible, age 65 and older population (i.e. civilian humanitarian care). The amount spent PMPM at NHP for the Medicare population was \$423. This amount does not include ancillary services. Comparatively, this amount is 26 percent less than the average amount spent on each Medicare eligible recipient in the state of Florida.

Health Metrix Research Inc., a leading research organization in the cost of Medicare HMOs, reports plans in three phases based on health status. These three phases are: good, fair and poor. Health status is determined by the amount of usage by the enrollee. NHP's NADD>65 empanelment average nearly 10 provider visits and 1 ER visit annually which closely matches the utilization rates of Florida's Medicare enrollees with fair health status. A participant with fair health status on average includes 12 provider visits, 1 ER visit, 1 inpatient stay of 3 days, and 24 prescriptions per year. HMO participants with fair health status average over \$1800 per year in out-of pocket expenses, which does not include their Medicare part B premiums (Health Metrix Inc, 2002). Overall, Florida's Medicare HMO enrollees average annual out-of-pocket expenses range from \$1000-\$3500.

Under TFL, eligible Medicare enrollees' out-of-pocket expenses are absorbed by the MHS for approved services. Therefore if the MHS can treat the NADD>65 population through unused capacity for less than the out-of-pocket expenses that would normally be absorbed by the

MHS, it makes financial sense to recapture this care in local MTFs. Capacity is a driving force in how much NADD>65 care can be accomplished within the MTFs.

Determining Capacity. Historically, enrollment has been set using a ratio of patients to provider. There are many sources available to estimate an average empanelment per provider based on the provider's specialty. Since TRICARE Plus operates much like a staff model HMO, enrollment should mirror that of a civilian staff HMO with expected variations for military primary care managers (PCM). Generically, capacity is defined as the number of available providers multiplied by the maximum number of enrollees per primary care manager. For example, a MTF with 20 primary care managers with a maximum enrollment of 1200 patients per provider would have a capacity of 24,000 enrollees. Available capacity, represented as a percentage, is derived by subtracting current enrollment from total available enrollment and dividing the results by total available enrollment. Using the above example of 24,000 enrollees, a MTF with 12,000 actual enrollees would have an available capacity of 50 percent ($24000 - 12000 = 12000$, $12000/24000 = .50$). A recent study sponsored by Aventis Pharmaceuticals found an average of 205 HMO members per PCM when all HMOs were taken into account. This figure is lower than actual PCM enrollment because many PCMs spread their enrollment over multiple HMO plans and other payors. However, enrollment figures more than tripled to 753 members per PCM when only staff model HMOs were considered (Adventis, 2000). In staff-model HMOs, PCM patient enrollment is more closely associated with member per PCM size because enrollment is usually limited to the specific plan enrollees. This is especially true in a closed staff-model HMO like TRICARE Prime. Another large-scale report, done in 1997, found an average of 779 members per PCM in staff model HMOs. The enrollment population in staff model Medicare HMOs was reduced to 661 enrollees per PCM (Kongstvedt, 2001). This

latter figure is better for comparison with TRICARE Plus, assuming that the majority of enrollees will be NADD>65. Determining if any of these figures are representative of MTF PCM enrollment is difficult to gauge, but it does give a measure to use for comparison.

MTFs generally have a smaller enrolled population than the private sector because of unique military requirements. A few examples include; increased military leadership duties, physical readiness requirements, annual leave, and military medicine specific education. In some military capacity models, military physicians have been considered .75 of a standard full-time equivalent (FTE) for enrollment purposes. Utilizing this assessment, a contracted civilian provider in a MTF may have an enrollment of 1000 patients and a military provider would have an enrollment of 750 (.75 x 1000). Reviews of enrollments throughout MTFs show great variation. NHP enrollment figures (October 2001) per primary care manager (PCM) vary from 0-1046 patients per provider (Table 1) and depend on the role and availability of the PCM. Enrollment figures presented are a snapshot and PCMs with an enrollment of zero were new arrivals to the Pensacola area at the beginning of FY02.

Table 1

PCM Enrollment by Clinic

Clinic	FP	IM	PEDS
Number of Providers	49	9	6
Total Enrollment	10,977	4,800	3,891
Low Enrollment	0	0	419
High Enrollment	379	1046	746
Avg Enrollment	201	435	648
Standard Deviation	90.957	361.545	135.559

Source: Director Healthcare Management and Plans, NHP (October 2001)

Accurate capacity modeling results in better access for enrolled patients and allows both the local MTF and the overall MHS to function more cost efficiently. At MTFs lacking accurate

validation procedures, including number of enrollees and type of patients, capacity can easily get out of control either through over-enrollment or under-enrollment.

Over-enrollment traditionally leads to patient dissatisfaction. Enrollees would have difficulty in acquiring timely appointments within the MTF and/or with their PCM as a result of over-enrollment. Thus, care would have to be received “outside the network” resulting in higher costs for the patient and the MHS. If access standards can’t be met, MTFs may be forced to disenroll patients at the MTF. In this scenario, the TRICARE Plus enrolled population would be disenrolled first. The failure to meet access standards, the higher costs associated with failure of delivery, and the possibility of disenrollment would ultimately lead to increased beneficiary dissatisfaction, a quality indicator.

On the other hand, under-enrollment has a greater cost impact on the overall Military Healthcare System (MHS). Under-enrollment leads to an increase in the number of available visits going unfilled. Any visit going unfilled may have a financial impact on the MHS as unfilled visits can result in a higher bid price adjustment process with the managed care support contractor (MCSC). The bid price adjustment process requires MTFs to have a minimum number of visits (Philpott, 2001). Therefore, if an MTF is not being fully utilized and falls short of the required number of visits, it increases the workload provided “in the network” resulting in higher overall costs to the MHS through an increase in TRICARE contractor costs. Therefore, under enrollment has a direct impact on higher costs per enrollee. Increasing enrollment in an under-enrolled environment will help reduce the bid price adjustment and result in overall MHS savings.

Increasing Enrollment. NHP plans to increase MTF enrollment of TRICARE Prime by 5000 beneficiaries over the next 2 years through new marketing efforts and realignment of

enrollment policies. It is estimated sixty percent of that increase will come from newly reporting personnel enrolling in TRICARE Prime at NHP. The other forty percent will be recaptured through marketing efforts of those currently in the Civilian Prime Network or those choosing the TRICARE Standard/Extra option.

There are over 30,000 beneficiaries, including Medicare eligibles, in the NHP catchment area that are not enrolled in TRICARE Prime at NHP. Of those, 11,000 are enrolled in the Civilian Prime Network and 10,000 are potential Medicare eligible TRICARE Plus enrollees (Naval Hospital Pensacola, 2002). While recapturing TRICARE Standard patients into TRICARE Prime is the most cost-effective approach, the assumption is that most of those beneficiaries who have elected TRICARE Standard over TRICARE Prime will continue to do so. Recapturing Medicare eligible beneficiaries through unused MTF capacity is cost efficient for the MHS and NHP up to the point of full capacity since TRICARE only pays 20 percent of an outpatient visit for an NADD>65 beneficiary. In other words, the marginal cost of an outpatient visit at the MTF is less than the average Medicare co-pay of treating any NADD>65 beneficiaries up to the point of full capacity. Additionally, future funding for NADD>65 care to MTFs will be based on level of effort. This level of effort will be base lined to FY2000 (TRICARE Management Activity, 2001). Any MTF that recaptures more NADD>65 care than they received credit for in FY2000 may receive additional funding for providing that care. Reimbursement determinations are being discussed at TMA and service specific agencies.

Purpose

The purpose of this study is to best determine the capacity (patient/provider) for enrolling beneficiaries into TRICARE Plus at NHP and thus assist in controlling the cost of care within the MTF and the MHS. The hypothesis of this study is that capacity and cost are functionally related

within a local MTF in regards to TRICARE Plus. Fully utilizing unused capacity in treating TRICARE Plus enrollees should reduce the overall cost of the MHS. A secondary hypothesis is that utilizing MTFs for cost savings is only achievable up to the point of current MTF capacity in regards to the NADD>65 population. After capacity is reached within a MTF, cost of providing care to the NADD>65 population is prohibitively more expensive to the MHS when the care is performed within the MTF because the MHS, as secondary payor to Medicare, is only responsible for the deductibles and cost shares of civilian care. In both instances, the null hypothesis is that no significant cost differences exist in regards to where the care is received regardless of available capacity.

Methods and Procedures

Assumptions

To answer the basic questions of capacity and costs of TRICARE Plus at NHP, a few assumptions must be made. First, while TRICARE Plus is open to all TRICARE beneficiaries not currently enrolled in TRICARE Prime or another HMO, it is expected that the majority desiring to enroll in TRICARE Plus will be age 65 and older. Other beneficiary categories already have the ability to enroll in TRICARE Prime and for whatever reason have elected not to do so. Additionally, those currently enrolled in TRICARE Prime, including NADD, are discouraged from changing enrollment from TRICARE Prime to TRICARE Plus because the guarantee to all levels of care and portability of the healthcare plan doesn't exist in TRICARE Plus. TRICARE Plus is a local MTF specific option, and not all MTFs are required to participate. Therefore, this study will focus primarily on NADD>65 beneficiaries and their impact on TRICARE Plus in relation to capacity management and cost efficiencies. Secondly, the study will not include the NADD>65 population already empanelled in Family Practice at

NHP for GME purposes except for historical usage comparison since these beneficiaries are already enrolled in TRICARE Plus. Third, since TRICARE Plus only guarantees access to primary care through a PCM, only outpatient, non-specialty care will be considered in this analysis. Lastly, any computations in this paper will assume MTFs are reimbursed at 50 percent of the average Medicare outpatient visit cost share. Based on the current average Medicare cost share of \$31, this model will use \$15.50 reimbursement per visit for any visit over the FY2000 level of effort baseline.

Clinic Capacity

Determining PCM availability for further enrollment was done using a comprehensive capacity model of the hospital's primary care clinics developed by NHP's Healthcare Plans directorate. A limit to this model is that current provider appointment availability is self-reported by the clinics, which may differ from actual capacity. The primary care clinics in the model include Family Practice (including the residency program), Internal Medicine, and Pediatrics. Data from fiscal year 2001 was used in this study. A formula was developed that takes into account the current mix of enrolled beneficiaries and their average primary care usage by provider type (staff physician, resident, etc.) by taking the number of beneficiary category (bencat) visits divided by the total visits and then multiplied by the number of bencat appointments per hour based on provider input. The formula gives a weighted average per beneficiary category. For example, a physician assistant (PA) in the Internal Medicine Clinic saw 2631 total patients of which 698 were active duty family members (ADFM). The PA reported that he/she could see 3 ADFMs per hour. Therefore, $(698/2631) \times 3.0$ yields the adjusted appointments per hour based on relative volume for an ADFM as .80 (rounded). See Table 2. This weighted average was used with current enrollment to determine current usage levels. This

model gives a very accurate assessment of current usage levels (Naval Hospital Pensacola, 2001). Model data can be adjusted on a periodic basis to demonstrate any change in enrollment mix.

Table 2

Appointments Per Hour for Relative Value by Beneficiary Category, Adjusted

Family Practice	Appts Per Hour Adjusted for Relative Volume by Bencat				Total Adjusted
	AD	ADFM	R & RFM <65	65 +	
Staff FP's, FNP's & PA's	0.55	1.21	0.93	0.30	2.99
Residents (3rd Yr)	0.24	1.46	0.91	0.30	2.91
Residents (2 nd Yr)	0.24	1.46	0.73	0.30	2.73
Residents (1st Yr)	0.12	0.97	0.52	0.23	1.83
Internal Medicine					
Internists		0.32	1.13	0.55	2.00
PA		0.80	1.51	0.69	3.00
Resource Sharing		1.34	1.65		2.99
Pediatrics					
Pediatricians		2.62	0.38		3.00
PNP		2.09	0.31		2.40

The adjusted appointments per hour multiplied by the number of hours in clinic (hours available per week multiplied by number of available week per year) yield maximum clinic appointment output. This output divided by average number of visits per enrollee will determine maximum visit capacity.

Enrollment Capacity

Research indicates that potential enrollees' outpatient visit patterns differ from current enrollees. Based on FY01 visit patterns, the average number of visits per enrollee for family practice, pediatrics, and internal medicine are 3.40, 3.34, and 2.95 respectively. Comparatively, Civilian Prime Network enrollees' average 3.2 visits per year (TRICARE Region 4, 2001) and Florida Medicare recipients average 6.8 visits per year (Adventis, 2000). The current usage

patterns of non-enrollees must be used to determine the potential number of enrollees to prevent over enrollment. As new enrollees' care is better managed in a primary care setting, annual visits should decrease. This decrease in usage will open the system for additional enrollees. Table 3 depicts the maximum number of potential enrollees by beneficiary category based on available visit capacity.

Table 3

Maximum Potential Enrollment based on Visit Availability

Beneficiary Type	Visits per Year	Avail Visits ^a	Maximum Recapture	Potential Enrollees
CPN Enrollees	3.2	45849	14161	11081
TS/E Beneficiaries	4.8	45849	9494	18120
Medicare Eligibles	6.8	38901	5721	10464

^a Available pediatric visits not included in Medicare Eligibles' visits

Cost Analysis

Current costs were calculated using a step-down process. MEPRS generically uses the weighted-average cost accounting method within the MHS. It steps down total costs to specific codes (i.e. outpatient). Once the step-down process occurs, MEPRS then averages the cost of a visit by taking the total cost of care divided by the number of visits. However, this methodology may be misleading in some instances. Since each visit consumes a different amount of resources, it could be argued some visits cost more than other visits (Zelman et al. 1998). In MEPRS, costs are equally dispersed among all visits; therefore the true costs of a particular visit can't be ascertained. In general, the formula for determining the cost of care is basically the number of visits divided by the total costs. In this study a similar step-down process was done. In this step-down process, all costs were allocated to a "cost center" to find the cost of services. Utility costs were stepped-down based on square footage. All other costs were based on full-time equivalent (FTE) fair share computations. Traditionally in healthcare, a "cost center" is a

patient interaction, revenue generating work center (i.e. clinic). Three cost centers were used in this study; outpatient services, inpatient services, and specialty services. Costs were allocated to the primary care clinics (FP, IM, and PEDS) as illustrated in Table 4. Ancillary services were not included because they are a separate cost under most healthcare plans. Additionally, the major ancillary service, pharmacy, should not be greatly impacted by this study because most beneficiaries that would considered joining TRICARE Plus most likely already have their prescriptions filled by NHP. Therefore, all ancillary related costs were removed prior to any calculations.

Table 4

Direct Costs Allocation per Cost Center

Workcenter	Direct Costs	Utilities	General Admin	Total Direct Costs
Utilities ^a	\$4,899,495	(\$4,899,495)		
Administration ^b	\$16,158,242	\$1,758,611	(\$17,916,853)	
Inpatient Services	\$11,108,397	\$1,335,721	\$4,411,200	\$16,855,317
Primary Care Clinics	\$11,344,571	\$1,164,070	\$3,845,662	\$16,354,303
Specialty Clinics	\$10,156,742	\$1,567,736	\$5,170,637	\$16,895,115

^a Utilities include repair and custodial services

^b Administration includes all administrative services not directly associated with particular service (i.e. Command Suite)

Note: Computations do not equal 100% because some operations are not allocated to clinical services (i.e. POMI)

Financial Source: Director Resource Management, Naval Hospital Pensacola

Square Foot Allocation Source: Facilities Department, Naval Hospital Pensacola

The Results

The results of this study are divided into four categories. First, the capacity of the MTFs outpatient clinics is presented. Second, NHP's current total cost of services is provided. Third, the estimated number of visits that can be recaptured is provided. Lastly, the effects of increased enrollment on NHP's total costs are presented. These four sections indicate that capacity and

cost are functionally related and that cost efficiencies can be ascertained by enrolling Medicare eligibles into TRICARE PLUS until maximum capacity is achieved.

Capacity

Unused capacity in the primary clinics was determined by subtracting the current enrollment level from total capacity. This model determined total availability (100 percent) by taking the total number of clinic provider hours per week multiplied by number of available weeks per year that they are available and further multiplied by average number of appointments per hour. This result was then divided by average annual enrollee visits to arrive at a maximum capacity in visits. FY01 visit data was derived from Composite Healthcare System (CHCS). Aggregate results of primary care clinics are provided in Table 5. 80 percent capacity is also shown because in any service related industry, which healthcare is a part, running capacity above 80 percent begins to impact access to services. For NHP primary care, impeding access will have a direct impact on higher network costs.

Table 5

Available Visit Capacity

Clinic/PCM	Hrs. Avail/ Week	Weeks Worked/ Year	Appts/Hr	Enrollment Capacity (Visits)	80% Capacity	FY01 Visits	Available Capacity (Visits)
Family Practice	601	44.00	2.67	70,478	56,382	37,818	46%
Internal Medicine	273	39.33	2.3	25,035	20,028	18,794	25%
Pediatrics	204	44.00	2.40	21,542	17,234	14,594	32%

Cost of Delivering Care

Four factors determine the total MHS costs of delivering healthcare. They are MTF costs (includes resource sharing), Civilian Prime Network (CPN) costs, TRICARE Standard (traditional CHAMPUS) costs, and TFL costs. Table 6 illustrates total MTF costs.

Table 6

Cost per Bed Day or Visit

Workcenter	Total Direct Costs	Visits/Bed Days	Costs per Bed Day or Visit
Inpatient Services	\$16,855,317	7977	\$2,112.99
Primary Care Clinics	\$16,354,303	180224	\$90.74
Specialty Clinics	\$16,895,115	56140	\$300.95

Visit/Bed Day Data Source: Director Healthcare Management and Plans, Naval Hospital Pensacola

The primary care visit costs outlined above in Table 6 do not include any ancillary services (i.e. pharmaceuticals). Further drill down of the data reflects of the \$90.74 spent in FY01 on a primary care visit, only slightly more than \$6 dollars is associated with variable costs (VC) of the visit. Similar results were noted in inpatient and specialty services too. The high fixed cost (FC) is primarily due to the low number of visits being spread across a high amount of labor costs.

Civilian Prime Network costs in support of over 11,000 beneficiaries totaled \$4,162,394 in FY00. Other NHP area TRICARE costs (Extra and Standard) totaled \$15,035,929 (Region 4 Lead Agent, 2001). Figures for TFL are not available. However, Table 7 is an estimated illustration of TFL costs. The cost of eligibles enrolled in the GME program is not included in the TFL cost calculation because these beneficiaries are already captured in total MTF costs. The estimated TFL cost per visit is 20 percent of the average Medicare outpatient visit.

Table 7

Estimated Current TFL Costs

NHP Area	Estimated TFL		
Medicare Eligibles	Outpatient Visits	TFL Cost per visit	Total Estimated TFL Costs
10464	71155	\$31.40	\$2,234,273

Current Visit Availability

Table 8 depicts the approximate number of available visits that went unfilled during FY01 based on capacity. With current staffing, NHP can recapture enough additional enrollees that will satisfy 37,000 to 46,000 annual visits.

Table 8

Available Visits

Clinic/PCM	Total Visits Avail	80% Avail Visits	FY01 Visits	Avail Visits Filled Pct	Current Avail Visits Unfilled	80% Avail Visits Unfilled
Family Practice	70478	56382	37818	54%	32660	26128
Internal Medicine	25035	20028	18794	75%	6241	4993
Pediatrics	21542	17234	14594	68%	6948	5559
NHP Total	117,055	93,644	71,206	65%	45,849	36,679

Capacity exists at NHP's three primary care clinics. There are two primary ways to gain efficiencies in capacity: reduce staff or increase enrollment. Since NHP catchment area has a demonstrated need for services, increasing enrollment seems to be the most logical, cost effective measure. Increasing enrollment will come from three areas; beneficiaries enrolled in the Civilian Prime Network (both ADD and NADD<65), TRICARE Standard/Extra beneficiaries, and the NADD>65 population through enrollment in the TRICARE Plus program. It should be pointed out again in this study that it is assumed most beneficiaries electing TRICARE Standard/Extra, for whatever reason, will continue to do so. They are not considered in any recapturing calculations. The next two tables depict recapturing capacity. Table 9 calculates recapturing all Civilian Prime Network beneficiaries into NHP TRICARE Prime before enrolling TRICARE Plus. Table 10 calculates recapturing ADD Civilian Prime Network

and TRICARE Plus beneficiaries. It assumes NADD<65 beneficiaries will remain in the Civilian Prime Network since they are not required to enroll at the MTF.

Table 9

TRICARE Plus Capacity Scenario One

Clinic/PCM	Current Avail Visits Unfilled	Civ Prime Visits for Recapture	Civ Prime Visits for Recapture (adjusted)	Avail Appts for TP	80% Avail Appts for TP	Avail TP Visits for Recapture	Avail TP Visits over 80% capacity	Clinic Capacity after Recapture
Total Appts		35,877				71155	68963	
FP	32660	28,535	26,128	6532			6532	100%
IM	6241		2,801	3440	2192	2192	1248	100%
Peds	6948	7342	6948					100%
NHP Total	45,849	35,877	35,877	9,972	2,192	2,192	7,780	100%
TP Enrollment Capacity					80 pct	322	100 pct	1466

Note: TP Visits = 10464 Medicare Eligibles multiplied by 6.8 (average number of annual visits by Medicare recipient in the state of Florida)

Table 10

TRICARE Plus Capacity Scenario Two

Clinic/PCM	Current Avail Visits Unfilled	80% Avail Visits Unfilled	Civ Prime Visits for Recapture	Avail Appts for TP	80% Avail Appts for TP	Avail TP Visits for Recaptures	Avail TP Visits over 80% capacity	Clinic Capacity after Recapture
Total Appts			15,480			71155	50500	
FP	32660	26128	10,465	22194	15662	15662	6532	100%
IM	6241	4993	0	6241	4993	4993	1248	100%
Peds ^a	6948	5559	5015	1933	544			72%
NHP Total	45,849	36,679	15,480	30,369	21,199	20,655	7,780	96%
TP Enrollment Capacity					80 pct	3,038	100 pct	4182

Note: Civilian Prime Visits = 4553 enrollees multiplied by 3.4 (average number of annual visits per enrollee)

Note: TP Visits = 10464 Medicare Eligibles multiplied by 6.8 (average number of annual visits by Medicare recipient in the state of Florida)

^a Estimated figure as a percentage of total enrolled population based on current NHP enrollment figures

The ability for NHP to open enrollment in TRICARE Plus for NADD>65 exist. Tables 9 and 10 suggest TRICARE Plus additional enrollment could range between 300 and 4200 depending on NHP's strategy on recapturing enrollees. Table 11 and 12 are cost benefit analyses of increasing enrollment. Graphical presentation of tables 11 and 12 showing estimated MTF Costs, Network Costs, and TFL costs are presented in Appendix A and B. Annual cost avoidance for the MHS would be over \$2.25 million. Cost savings, based on reimbursement for recapturing TRICARE PLUS visits, for NHP could be as high as \$100 thousand annually. Figure 1 illustrates total cost savings of increasing enrollment based on scenarios one and two. In Table 12, there is a surplus of pediatric visits after recapturing all ADD Civilian Prime Network beneficiaries because it is assumed that TRICARE Plus will enroll mainly NADD>65. Therefore, no available pediatric visits were associated with TRICARE Plus enrollees.

Table 11

Total Cost based on projected enrollment maximizing total CPN Recapture

Primary Care Visits	Increased MTF Visits	CPN Visits ^a	TP Visits ^b	TFL Visits ^b	Total Visits	Total Care Costs
Current (FY01)	N/A	35877	0	71155	107032	\$23,753,608
	10000	25,877	0	71155	107032	\$22,653,608
	15000	20,877	0	71155	107032	\$22,103,608
	20000	15,877	0	71155	107032	\$21,553,608
	25000	10,877	0	71155	107032	\$21,003,608
	30000	5,877	0	71155	107032	\$20,453,608
	35000	877	0	71155	107032	\$19,903,608
80% Capacity	38069	0	2,192	68963	107032	\$19,751,461
	40000	0	4,123	67032	107032	\$19,702,414
	45000	0	9,123	62032	107032	\$19,575,414
100% Capacity	45849	0	9,972	61183	107032	\$19,553,849
	50000	0	14,123	57032	107032	\$19,823,414
	107032	0	71,155	0	107032	\$22,499,801

^a Non-referral visits only

^b Does not include the NADD>65 beneficiaries currently enrolled

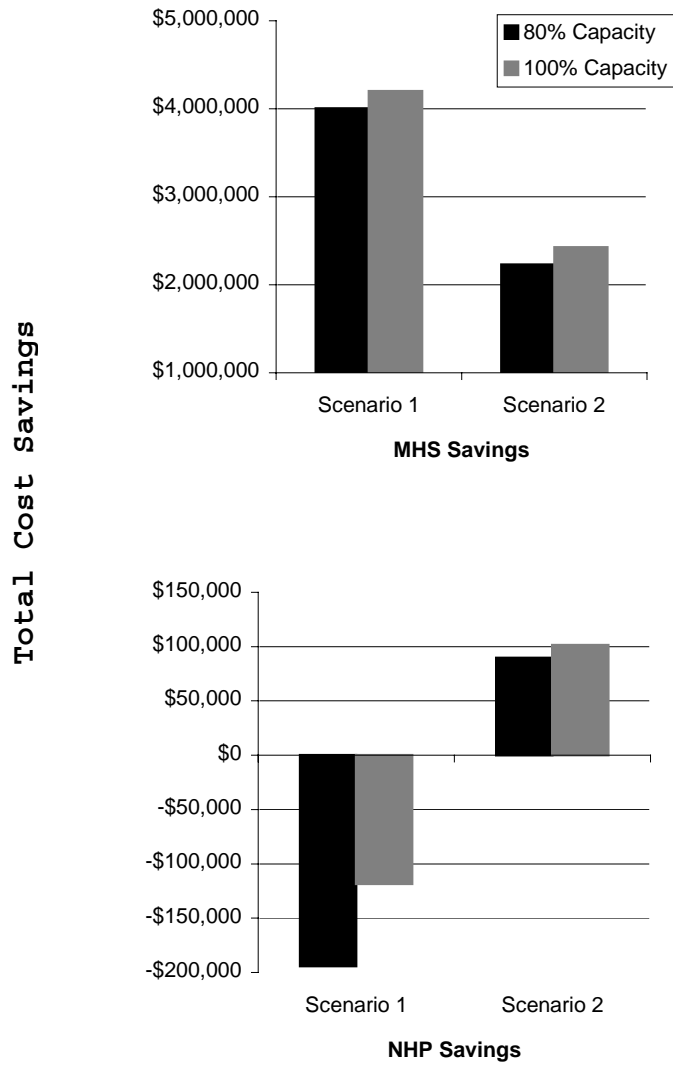
Table 12

Total Cost based on projected enrollment, ADD CPN Recapture Only

Primary Care Visits	Increased MTF Visits	CPN Visits ^a	TP Visits ^b	TFL Visits ^b	Total Visits	Total Care Costs
Current (FY01)	N/A	35877	0	71155	107032	\$23,753,608
	10000	25,877	0	71155	107032	\$22,653,608
	15000	20,877	0	71155	107032	\$22,103,608
	20000	20,397	4,520	66635	107032	\$21,936,000
	25000	20,397	9,520	61635	107032	\$21,809,001
	30000	20,397	14,520	56635	107032	\$21,682,000
	35000	20,397	19,520	51635	107032	\$21,555,000
80% Capacity	36135	20,397	20,655	50500	107032	\$21,526,171
	40000	20,397	24,520	46635	107032	\$21,428,000
100% Capacity	43915	20,397	28,435	42720	107032	\$21,328,559
	45000	20,397	29,520	41635	107032	\$21,376,000
	50000	20,397	34,520	36635	107032	\$21,624,000
	86635	20,397	71,155	0	107032	\$23,443,471

^a Non-referral visits only^b Does not include the NADD >65 beneficiaries currently enrolled

Figure 1. MHS and NHP total cost savings based on enrollment capacity and scenario.



Discussion

As demonstrated in the results, secondary questions had to be answered prior to determining whether capacity for TRICARE Plus existed at NHP and at what cost impact TRICARE Plus would have. These questions included; finding out total capacity, where capacity existed, and the total current cost.

Total capacity was achieved through self-reported provider availability input compared to actual FY01 primary care visits. This calculation verified that unused capacity existed. Next, the number of visits available in each primary clinic was calculated. Calculating capacity based on visits instead of percentage of enrollment is vital because potential enrollees have a significant different usage pattern than those currently enrolled. For example, NADD>65 currently enrolled to the Family Practice clinic have an average of 4.11 visits per year whereas the Medicare recipients in Florida average 6.8 visits per year. Knowing the capacity levels in each clinic is a key ingredient in the strategy to increase enrollment. Another key ingredient is the cost of delivering healthcare.

The average, current cost of a NHP primary care visit is slightly less than \$91. The average government cost of a TRICARE approved visit to a civilian provider is \$111. The estimated cost share for a TFL visit is \$31.40. Table 13 depicts projected costs based on increasing visits at the NHP. Network costs are eliminated after 35,877 visits are recaptured. TFL costs are eliminated after 107,032 visits are recaptured.

Table 13

Total Cost based on projected enrollment

PC Visits	Increased MTF Visits	MTF Fixed Costs	MTF Variable Costs	MTF Total Costs	Network Costs	TFL Costs	Total Care Costs
FY01	N/A	\$16,224,000	\$1,133,609	\$17,357,609.00	\$4,161,732	\$2,234,273	\$23,753,614
	20000	\$16,224,000	\$1,253,609	\$17,477,609.00	\$1,841,732	\$2,234,267	\$21,553,608
	30000	\$16,224,000	\$1,313,609	\$17,537,609.00	\$681,732	\$2,234,267	\$20,453,608
	40000	\$16,224,000	\$1,373,609	\$17,597,609.00	\$0	\$2,104,805	\$19,702,414
100% Cap	45849	\$16,224,000	\$1,408,703	\$17,632,703.00	\$0	\$1,921,146	\$19,553,849
	55849	\$16,599,000	\$1,468,703	\$18,067,703.00	\$0	\$1,607,146	\$19,674,849
	65849	\$16,974,000	\$1,528,703	\$18,502,703.00	\$0	\$1,293,146	\$19,795,849
	75849	\$17,349,000	\$1,588,703	\$18,937,703.00	\$0	\$979,146	\$19,916,849
	85849	\$17,724,000	\$1,648,703	\$19,372,703.00	\$0	\$665,146	\$20,037,849
	95849	\$18,099,000	\$1,708,703	\$19,807,703.00	\$0	\$351,146	\$20,158,849
	107032	\$18,324,000	\$1,775,801	\$20,099,801.00	\$0	\$0	\$20,099,801

Conclusions and Recommendations

Capacity management can become more efficient by increasing enrollment at NHP and can result in cost savings for NHP and the MHS. Maximizing capacity would drive the average cost of a primary care visit down to \$43.50 at NHP. While current cost per visit is 22 percent less than the average cost of a civilian provider visit, maximizing capacity results in a 155 percent savings. However, current unused capacity (45,849 visits) limits the number of potential enrollees that can be recaptured. Three sources exist for increased enrollment: ADD and NADD<65 Prime enrollees in the Civilian Prime Network, TRICARE Standard/Extra beneficiaries, and the Medicare eligible population through enrollment in TRICARE Plus.

The most cost effective approach for the MHS is to recapture all Civilian Prime Network enrollees. However, current NHP policy does not require any network enrollee to abandon their current patient/provider relationship in favor of enrolling in NHP TRICARE Prime. New Tricare Prime enrollees have been required to enroll at NHP since February 2002. In a three to four-year period, this should attrite most ADD beneficiaries from the Civilian Prime Network. Under

current policy, NADD<65 enrolled in the Civilian Prime Network will continue to do so until they relocate outside NHP catchment area, disenroll from TRICARE Prime, or elect to abandon their current provider relationship in favor of NHP's TRICARE Prime option. Although it is possible to recapture over 11,000 beneficiaries from the Civilian Prime Network, it is the conclusion of this author that only the ADD will be recaptured. Heavy marketing efforts may attract some NADD<65 enrollees, but without requiring formal conversion, few will abandon their current healthcare relationships.

TRICARE Standard/Extra beneficiaries are the second most cost effective approach to increase enrollment. However, this population has already chosen not to enroll in TRICARE Prime, including the Civilian Prime Network, for whatever reason. It is the conclusion of the author that few, if any of these beneficiaries will enroll in TRICARE Prime unless drastic changes in benefits (perceived care, copays, etc.) occur, which are not expected in the near term.

Medicare eligibles may not be the most cost effective approach, but they are cost effective up until capacity is achieved. Also, they are probably the most attractive population to market. In many cases, they are eager to receive their care at a MTF where they already get their medications. In essence, "a one-stop shop." Arguably, they could be considered the MTF's most loyal customer. Additionally, MTFs that attract NADD>65 care to their facility may gain increased funding from the "accrual fund", a fund set up to pay for NADD>65 care beginning in fiscal year 2003 (FY03). The dilemma in attracting Medicare eligibles back into the MTF is that now their care with a civilian provider is essentially free so long as they pay Medicare Part B premiums. Also, this population was forced out of the MTFs when they turned age 65. Recruiting them back may prove difficult. However, this population may still be the second best source for increasing enrollment outside the ADD population.

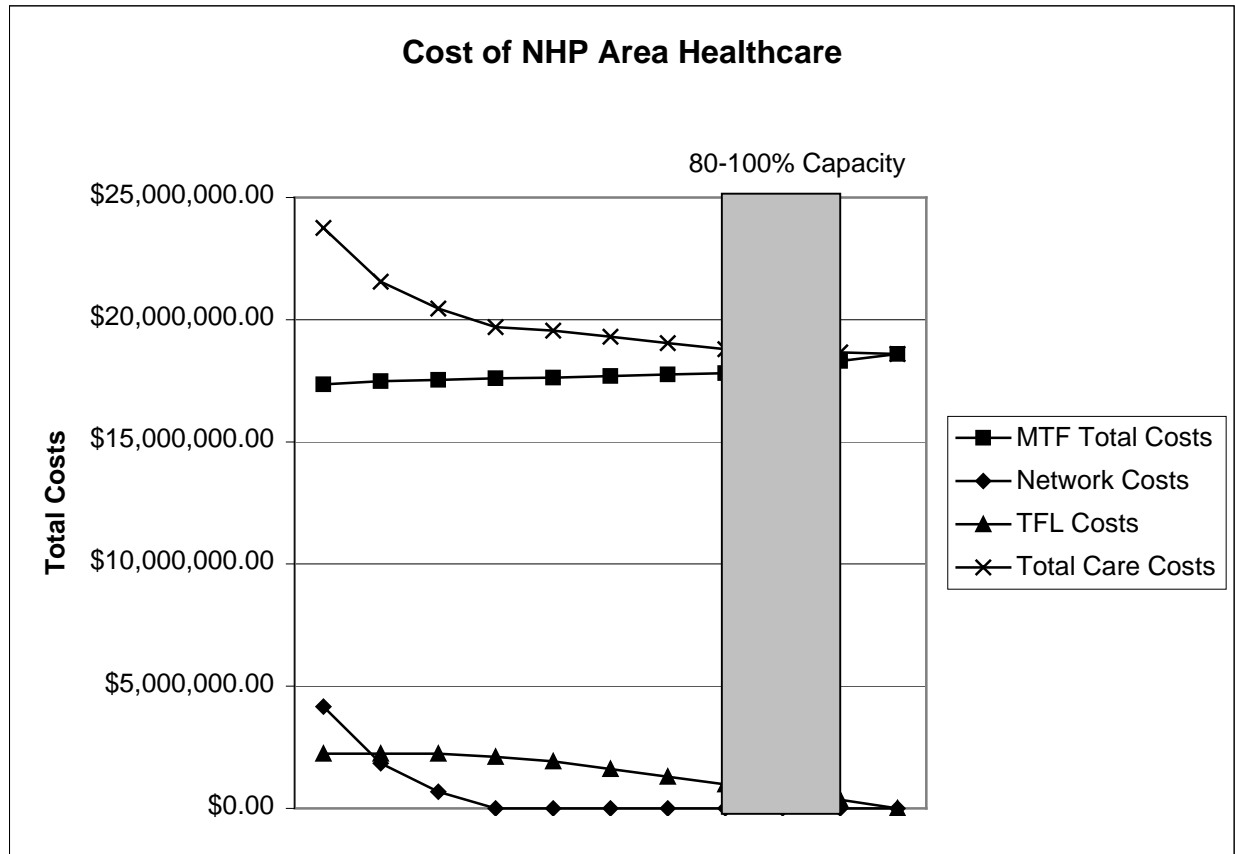
Two courses of action are depicted in Tables 11 and 12 in the results section of this paper. Although there are two other courses of action, they are without merit. The first would be maintaining the status quo, which is not efficient or effective as it pertains to capacity or cost. The second, eliminating staff to meet efficiencies, is not viable in a market that has a demonstrated need for services and an operational commitment for the active duty staff.

Of the two viable options, the first scenario would recapture all Prime beneficiaries currently enrolled in the Civilian Prime Network before increasing any TRICARE Plus enrollment. The second scenario looks at increasing TRICARE Plus enrollment based on projected numbers of ADD beneficiaries being recaptured from the Civilian Prime Network. The second scenario does not forecast any NADD<65 enrollees coming back into NHP's TRICARE Prime. Neither scenario directs efforts to recapture TRICARE Standard/Extra beneficiaries because it is concluded that they are the hardest population to attract and the least likely to enroll.

The second option is the recommended approach for NHP for two primary reasons. First, it attracts the most marketable populations, ADD and NADD>65. Secondly, as both scenarios produce significant savings for the MHS, only the second scenario has the potential to produce actual cost savings for NHP through estimated reimbursements from the NADD>65 accrual fund. At 80 percent capacity, the second scenario will increase TRICARE Prime enrollment by over 4500 and TRICARE Plus enrollment by at least 3000 from December 2001 levels. TRICARE Plus enrollment could increase an additionally 1100 if maximum capacity was considered. At 80 percent capacity, the increased enrollment will result in annual savings of \$90 thousand and \$2.25 million for NHP and the MHS respectively.

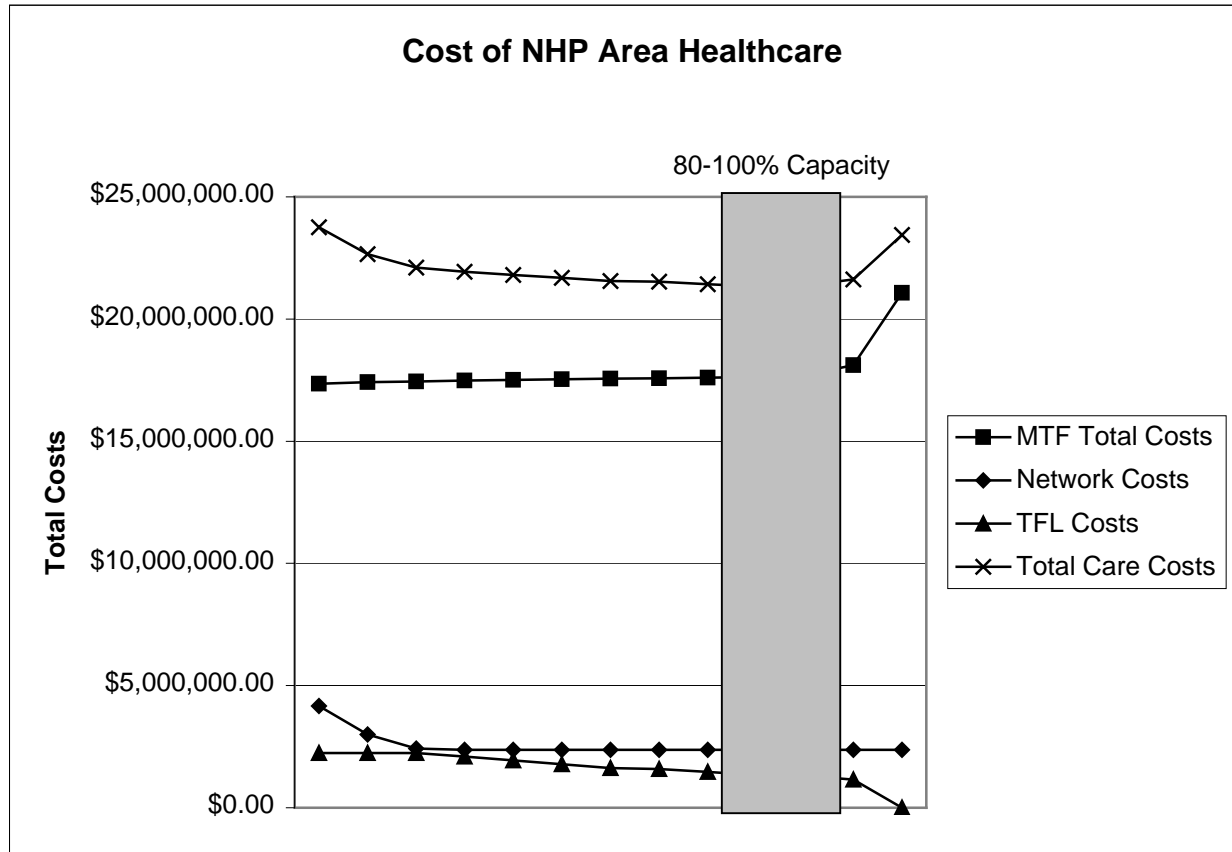
Appendix A

Figure A1. Estimated NHP Catchment Area Healthcare Costs with 100% CPN Recapture.



Appendix B

Figure B1. Estimated NHP Catchment Area Healthcare Costs with ADD CPN Recapture Only.



Appendix C

Alphabetical List of Key Acronyms Included in this Paper

AD	Active Duty Service Member
ADD	Active Duty Dependent
Bencat	Beneficiary Category
ADFM	Active Duty Family Member
CDR	Commander, United States Navy
CHAMPUS	Civilian Health and Medical Plan of the Uniformed Services
CHCS	Composite Healthcare System
CPN	Civilian TRICARE Prime Network
CY	Calendar Year (Jan – Dec)
DAA	Defense Authorization Act
DoD	Department of Defense
FY	Fiscal Year (Oct – Sep)
GME	Graduate Medical Education
HMO	Health Maintenance Organization
LCDR	Lieutenant Commander, United States Navy
MAJ	Major, United States Army
MEPRS	Military Expense Performance Reporting System
MHS	Military Health System
MTF	Military Treatment Facility (Hospital)
NADD<65	Non-Active Duty Beneficiary under the age of 65
NADD>65	Non-Active Duty Beneficiary over the age of 65 (Medicare Eligibles)
NHP	Naval Hospital Pensacola
NMOP	National Mail Order Pharmacy
NP	Nurse Practitioner
PA	Physician Assistant
PC	Primary Care
PCM	Primary Care Manager
PPO	Preferred Provider Organization
TP	TRICARE Plus
TFL	TRICARE for Life

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